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ABSTRACT

In 1976, suicides in the 15-24 year-old group (N=4,747) made up over 17% of all suicides in all age groups (N=26,750). In 1968, adolescent suicides (N=2,591) were only 12% of the total (N=21,000). Adolescent suicide rate is alarming unless put into perspective with the accident rate and the cultural belief in individual rights, responsibility, and achievement. The rate of adolescent suicides in 1976 was 11.7 per 100,000 15-24 year olds, but the accident rate was 59.9 for the same group (N=23,960). Accident rate ranks first in cause of deaths while suicide rate ranks third, but the difference between first and third is large. One theory about the increase in adolescent suicide is examined in terms of the hopelessness felt by them. They are told by the culture that they have the right and the responsibility to achieve at a time when the means for doing so are diminishing. (Author)

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ADOLESCENT SUICIDE AND INTERVENTION IN PERSPECTIVE

The mass media are exclaiming about a dramatically rising suicide rate among adolescents and are calling desperately for prevention and intervention. This warning needs to be seen in perspective. The intent of this paper is not to diminish the seriousness of suicide and suicide attempts for the individual, the close family and friends, or the society. Rather, the purpose is to compare suicide rates with rates for other types of deaths, to show the origin of prevailing attitudes toward suicide, to present some theories about suicide, and to discuss prevention and intervention in order to have a better picture of the issues.

Actual Suicide and Substitutes for Suicide

Suicide is a conscious and deliberate attempt to take one's life quickly, usually by means of excessive pill or drug ingestion, gunshot, knife or sharp object, or jumping from a high place. The ratio between attempted suicide and actual suicide, however, is 8 to 1. There is a higher ratio of attempted to completed suicide among young people and among females. Substitutes for suicide which end in death, but are not consciously planned for one's demise, often are alcoholism, drug overdose, mismanagement of a physical disease, participating in high risk activity, antisocial behavior, losing the will to live, and seriously inadequate diet, rest, and exercise.

Those who complete suicide are described as a different population from those who attempt suicide and those who substitute the so-called "partial death." Those who attempt suicide or substitute behavior that is not life supporting have little intention of dying and are seeking help for a reason for living (Shneidman, 1976).

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Rates of Suicide

The claim that the adolescent suicide rate has risen dramatically over the last two decades needs to be compared to rates for other causes of death and to suicide rates for the total population. Also, this rate should be explained and translated into numbers (see Table 1).

The rate of suicide for the 15-24 year olds in 1968 was computed to be 7.2 per 100,000 in this age group. Compared with 11.7 in 1976, there was a 62 percent increase in rate and almost total population of all ages was 10.7 in 1968 (N = 21,400) and 12.5 in 1976 (N = 26,750), a 16 percent increase in rate and about a 25 percent increase in number.

The rate of accidents for the 15-24 year olds in 1976 was 59.9 which resulted in 23,960 deaths in comparison to a suicide rate of 11.7 resulting in 4,747 deaths. Accident rate ranks first in cause of deaths while suicide rates rank third, but the difference between first and third is enormous.

Male accident and suicide rates are far higher than female rates and are increasing more rapidly. Black male adolescent suicide rates are higher than other suicide rates.

The rate of suicide might increase somewhat and the rate of accidents might decrease somewhat if the deaths attributed to accidents or even to natural causes or to homicides were accurately assessed. One-car accidents from speeding, encouraging a fight, and excesses of daily living might really be suicides or sub-intentional suicides. However, Perlin (1975) found that a group of people who completed suicides were assessed as significantly different from a group who died from one-car accidents.

Attitudes Toward Suicide

Suicide is generally seen more emotionally than are other causes of death. The difference comes from the prevailing Western cultural attitude

that suicide is wrong and could have been prevented. This attitude stems mainly from a Christian view that suicide is self murder and therefore immoral. This notion became a rule of the Catholic church in 693 and has affected the Western world since that time. However, philosophers by the 18th century (Hume and Rousseau) discussed suicide apart from a personal sin. Rousseau placed the sin on societal failures and Hume thought individuals had as much right to choose to die as to choose to change any other part of the world. In the 19th century, Durkheim followed the idea that society is to blame for individual problems. Freud, in the 20th century, said suicide came when the ego was cut off from or rejected by a love object. Internalizing object in ego, the hostility is vented on self instead of others. Thus came the psychodynamic notion that suicide is a mental illness. More recent attitudes are turning toward the right of individuals to decide for themselves when the price of living is too great to pay, a combination of humanism and behaviorism (Alvarez, 1972; Shneidman, 1976).

The stigma that suicide places on the survivors exemplifies prevailing attitudes. When there is the belief that the environment plays a large part in suicide, the immediate family and close friends feel guilty for not having made life more worthwhile for the person. Couple the guilt with the notion that suicide is immoral and the stigma is even greater. When one's belief is that suicide is a matter of psychodynamics, the survivors feel guilty for not having recognized the symptoms and intervened. When the survivors believe that people have a right to decide how to die, they are more objective. Since all three attitudes prevail, they each seem to affect all survivors to some degree.

Theories About Suicide

Suicide is believed to conform to general laws or principles and recently the study is called Suicidology (Shneidman, 1976). Sociological models assume that suicide is the result of society's relationship with man. In 1897, Durkheim (1951) described three basic types of suicide: (1) altruistic suicide in which the self-inflicted death is expected under certain circumstances in the society; (2) egoistic suicide when the person has too few ties with other persons and the community, and (3) anomic suicide when the person has a sudden change of self status. Most sociologists since have used Durkheim's model with variations. The rising divorce rate, insecure job market, too high expectations, and unsure future are given as reasons for egoistic and anomic suicide.

Psychodynamic models suggest that the suicide prone mechanisms are rage, guilt, anxiety, and lack of independence or control which turn into hopelessness and helplessness (Litman & Tabocknick, 1968). Farber (1975), a student of Kurt Lewin, described his theory of suicide by postulating that as hopelessness goes down, suicide goes up. Low hopelessness is a function of high threat to life conditions in face of a lack of competence to deal with the threat. A good outlook on life is the converse. Adolescents may acquire a hopelessness when they have not learned adequate life skills. The use of alcohol and drugs helps numb people against the hopelessness.

Both the sociological and the psychodynamic approaches would be tempered by one's basic philosophy of life. When one believes that humans have choices among alternatives, then the reaction to situations would differ. Since choices are cognitive and cognitions are affected by levels of energy, then under conditions too heavy to handle, the person becomes the reactor and not the actor.

Prevention and Intervention

No matter whether the theoretical perspective is sociological or psychodynamic, prevention and intervention appears to come from the belief that there is a duty to help other people. Shneidman (1976) described prevention as essentially providing oneself and others with good mental health. Intervention comes only after one has shown suicidal tendencies or has attempted suicide. "Postvention" is a term used to describe the work involved with assuaging the guilt and shame of the relatives and friends of a person who has committed suicide.

Symptoms of suicide, especially among adolescents, are sudden changes in studying, sleeping, eating, and social activities, particularly those resulting in depression and loneliness (Shneidman, 1976). Depression in children sometimes shows up as oversleeping whereas it causes insomnia in adults (Usdin, 1977), therefore sudden changes in an adolescent's life should not be interpreted in the same way as change in an adult's life.

Some psychological characteristics of suicide are these: (1) acute crisis, an interval of relatively short duration (hours or days) in which a person bent on self destruction is either helped, cools off, or is dead; (2) ambivalence, a phenomenon of duality in that suicidal persons both want to die and do not want to die and therefore can listen to an intervener; and (3) dyadic, that is, two-person events in which there was some loss of connection with a significant other which results in a loss of personal identification but lends itself to the value of the relationship with the interviewer (Shneidman, 1976).

Intervention by untrained persons is valuable simply because of the one-to-one relationship set up. Going further than talking and listening

within the current time and situation is not recommended. Probing as to why and determining a rehabilitative action is best left to professionals.

Uniqueness of Adolescent Suicide's Upward Trend

Some explanations for this uniqueness of adolescent suicide's upward trend are (1) the increased pressure for more adolescents to stay in school where success is difficult, (2) higher expectations for personal well being than society or others can offer, and (3) more available means for suicide.

Adolescents now are also more free to follow their own rules. Often they do not have the training, experience, or wisdom (competence) to choose between activities that will be successful in meeting life's demands. This helplessness then leads to hopelessness. Many adolescents now have too many opposing pressures under which their limited experience allows them to feel there is no way out. Often pressures to grow up fast yet stay dependent puts them in a no-win situation.

Other factors affecting adolescents are the lack of opportunities to work, over-education for jobs available, and adult models of depression about the existing state of the world. These adults are griping in perspective of time and experience, but adolescents see only their first view of the world beyond childhood.

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FILMS

- "But Jack Was a Good River" (Possibility of suicide). 1974.
(16 mm color, 14 minutes). Association Films: 5797 New Peachtree Road, Atlanta, Georgia 30340, rental \$21.00.
- "Depression and Suicide: You Can Turn Bad Feelings Into Good Ones."
(16mm color, 26 min.). New York University, 26 Washington Place, New York, N.Y. 10003, rental \$30.00.
- "The Suicide Syndrome."
(16mm film or videotape). Medi-Tel Communication, 565 Fifth Avenue, New York, N.Y. 10017, rental \$50.00
- "Suicide."
(16mm color, 25 min.). Films, Inc., 1144 Wilmette Ave., Wilmette, Ill. 60091, rental \$23.00

"Suicide: It Doesn't Have to Happen."

(16mm color, 21 min.) BFA Educational Media, 2211 Michigan Avenue,
P.O. Box 1795, Santa Monica, CA 90406, rental \$22.00.

Table 1

Rates and Numbers of Suicide and Accidents by Age and Year
(Rates based on number per 100,000 population in each category)

	1958 ¹			1968 ¹			1970 ²		1976 ²	
Causes	10-14	15-19	20-24	10-14	15-19	20-24	5-14	15-24	5-14	15-24
<u>Suicide</u>										
Total	0.5	3.0	7.0 (750)	0.6 (126) ²	5.1 (969)	9.6 (1,632)	0.3 (132)	8.8 (3,128)	0.4 (163)	11.7 (4,747)
Male	0.8	4.3	11.1	0.9 (189)	7.6 (1,444)	14.8 (2,516)	0.5 (105)	13.5 (2,378)	0.7 (126)	18.5 (3,786)
Female	0.2	1.7	3.1	0.2 (42)	2.2 (418)	4.7 (799)	0.2 (30)	4.2 (750)	0.2 (37)	4.8 (961)
<u>Accidents</u>							1970 ³		1976 ²	
Total							20.1 (8,200)	68.7 (24,388)	17.0 (6,290)	59.9 (23,960)
Male							27.4 (11,179)	110.5 (39,227)	22.9 (8,473)	94.1 (37,640)
Female							12.5 (5,000)	27.6 (9,798)	10.8 (3,996)	25.3 (10,070)
<u>Natural Causes</u>										
Total							12.0 (4,896)	19.1 (5,790)	10.0 (13,550)	13.9 (5,643)

¹Source: Shneidman, 1976

²Source: National Center for Health Statistics, 1978

³Source: National Center for Health Statistics, 1974